

MEETING DATE: May 23, 2008

TO: Mary Helmers, ND Medical Assistance
FROM: Greg Lord, MAMES State Chair
DATE: April 11, 2008
SUBJECT: ND MAMES Providers Questions for ND Medical Assistance

These questions are compiled & edited by Greg Lord of Great Plains Rehabilitation Services, 701-530-4000. Members from the ND MAMES task force submitted these questions and will meet NDMA at the North Dakota State Capital in Bismarck at 1:30 pm, Wednesday, April 23, 2008.

PRESENT: Greg Lord (Great Plains Rehab), Mitch Evenson (Medquest-Williston), Todd Flicek (Great Plains Rehab), Barb Stockert (HealthCare Access.), Steve Jacobchick (Medequip One), Kurt Schmidt (GPRS), Troy Lapp (Medequip One), Jody Anderson (Altru Health System), Kevin Holzer (Great Plains Rehab), Gail Urbanec (Medquest Dickinson), Kaloa Wade (Medquest Dickinson), Maggie Anderson (DHS), Eric Elkins (DHS), Dan Johnson (DHS), Tammy Renner (DHS), Mary Helmers (DHS)

POWER TILT SYSTEMS

A ND MAMES Provider has recently encountered several individuals that the physician feels that a power tilt systems is medically necessary to be added to their power chairs. NDMA has generally resisted paying for these types of systems.

The NDMA explanation for denying the service is because "caregivers are presently being paid to care for some of these individuals needs...and they should be doing all the weight shifts throughout the day." Depending on the type of care they are getting and the frequency that people must have some type of weight shift this is not possible.

The physician's reason for prescribing a power tilt system is to give the NDMA beneficiary better function and independence.

The intention of most medical equipment/devices is to offer people function & independence. It also saves tax dollars by keeping the beneficiary active and not forcing them to a nursing home.

Only after parents are getting involved in voicing their need for physician prescribed tilt systems...are they getting approved. Is there a reason that power tilt systems should not be covered?

RESPONSE: NDMA has not resisted payment for power tilt. If the recipient has total care in the home, that caregiver is available to assist with weight shifts, help with transfer between the bed and chair, etc. To ensure federal funding requirements are met, items covered by the Department must be: Reasonable and necessary in amount, duration and scope to achieve their purpose, the most economical and efficacious available to fulfill the BASIC medical need, ordered by a physician, covered only for recipients who reside at home, and dispensed as quickly as possible due to the medical necessity identified for an item.

We will need to review and reassess our coverage guidelines for power tilt systems.

DISCUSSION: Manual tilt will still be available for manual wheelchairs. Providers will gather information as to what percent of wheelchairs they dispensed per year would potentially require a power tilt so NDMA can evaluate the potential financial impact. NDMA will follow strict Medicare guidelines for coverage criteria.

SUSPENDED CLAIMS

A ND MAMES Provider receives the NDMA “suspended report” on a regular basis. In viewing this report it seems the NDMA backlog of suspended claims is getting larger instead of smaller. This raises the following concerns:

Why would this list be getting larger when ND MAMES Providers were told NDMA was increasing staffing hours to handle all the claims received?

ND MAMES Providers realize that claim submission and processing is a two way street and many times claim might be suspended because of an error by the provider.

1. Is there a report by provider that ND MA can run that will show the most common reasons a claim might suspend? If such a report could be generated, this would show the ND MAMES providers what they are doing or not doing that causes this to happen.

What is NDMA's self-assessment on its current claims processing timelines?

RESPONSE: Overall claims in suspense have decreased; however, this may not be the case for a particular provider. We would need to know the provider in order to determine why they are seeing an increase in suspended claims.

DISCUSSION: Providers are to call provider relations to request a suspense list. Erik Elkins ran a report to identify some of the most common reasons why DME claims are in suspense. Results of this report are attached at the end of these meeting minutes. This report is from April 28th check write.

Maggie Anderson made a recommendation to the DME providers to submit electronic claims whenever possible as they would see a more timely reimbursement on their clean claim.

LABOR

This question from ND MAMES Providers was regarding labor only issues and not maintenance and servicing. Providers voiced concern about not allowing labor coverage when no parts are billed. The labor only issue would be, in most cases, related to wheelchair repairs that neither the recipient nor the caregiver would be able to perform the repair themselves.

RESPONSE: NDMA would need to know what types of repairs that either the recipient or the caregiver would not be capable of performing and an explanation why not.

The Providers will create a recommended policy for labor only coverage and this policy will be presented to the Claims Policy Staff. However, Providers request further discussion with NDMA to understand what may be included in designing a policy.

DISCUSSION: Discussion concerning types of repairs, teaching recipients minor repairs vs. DME providers completing the repairs, recipient may not have a caregiver or guardian to help with repairs and upkeep. DME providers do bill other payors for this type of service. Medicare will have new guidelines out in a month or so and NDMA will consider adopting this policy. Jody A. brought up the fact that recipient may not always be aware of the need for repairs.

ADULT & SPECIALTY DIAPERS

Discussion at the July 23rd, 2007 Q&A was on ND MAMES Provider costs for adult diapers. The response from NDMA was in was put on hold during the Legislative Session. NDMA was to look at reimbursement and monthly quantity limits. It was also written that we must stay budget neutral.

Providers feel strongly that the burden of “budget neutral” should not be placed on the backs of Providers. If NDMA wishes to continue paying for adult & specialty diapers than a reasonable fee schedule should be provided.

RESPONSE: We welcome providers to submit billing data to reflect quantity dispensed per month per recipient. The Department will then evaluate if an increase in reimbursement can be considered. Yes, we need to stay budget neutral and also to insure that we will due no harm to recipient's by decreasing quantity limits only to increase provider reimbursement.

DISCUSSION: Providers are to gather and submit information related to number of recipients they provide diapers for, the quantity per month dispensed per recipient, the size of the diaper and the providers cost to supply that particular diaper size.

Informed the DME providers we do need to stay budget neutral and that they will get a 5% increase in July but they feel that this still will not cover the cost especially for the larger size diapers.

Providers should only request the quantity per month that the recipient requires rather than requesting the maximum allowed quantity per month. Providers should be calling recipients regarding their monthly need and requesting this amount per month.

STANDERS E0637

NDMA allowable for Standers E0637 is \$950.00. Most insurance companies reimburse at \$2000.00+ for this HCPC Code. How was the current NDMA reimbursement for E037 configured? Can this amount be reevaluated because most providers cannot even buy them at this price?

RESPONSE: The Department will collect data and reassess the current fee on the fee schedule.

DISCUSSION: NDMA is currently looking and comparing reimbursement amounts from other State Medicaid Agencies. Discussions regarding supine vs. sit to stand type standing frames. The type and style of stander is to be recipient driven and not caregiver driven.

Providers are to request the most economical and efficacious equipment available to fulfill the basic medical needs of the recipient.

INTERMITTANT CATHETERS A4351/A4352

NDMA had just increased their allowable on Intermittent Catheters A4351/A4352 from four per month to 200 per month. This change goes into effect April 1st. Will NDMA be following Medicare guidelines on these products? If so, will these be expected to be prior authorized? What will the NDMA procedure be?

RESPONSE: At the present time we will not consider increases the monthly quantity limits. We will review and make exceptions on the quantity limit when medically necessary. Example: Frequent UTI.

DISCUSSION: For NDMA purposes, if providers are requesting quantities in excess of the set monthly allowable, as identifies on the online fee schedule, they are required to provide medical documentation to support this request and an exception will be considered.

The Medicare policy allows up to 200 per month for recipients with extreme utilization requirements and sufficient information in the medical record to justify the amount ordered.

SHIPPING & HANDLING

What is the NDMA policy for charging shipping and handling from ND MAMES Provider to NDMA beneficiary? Generally, a Provider will absorb the shipping/handling from manufacturer/vendor to the Provider. But often items are mailed or shipped to recipient since they cannot pickup the item and/or live a substantial distance from the Provider. With the huge increases in those charges, the Provider can no longer absorb all the shipping/handling expense. Can a Provider charge shipping costs to the NDMA beneficiary?

RESPONSE: Costs incurred for shipping and handling are considered to be a part of the DME provider's overhead/business expenses. Separate shipping and handling charges will not be allowed and can not be billed to the recipient.

DISCUSSION: Same as above.

PRIOR AUTHORIZATION NUMBERS

A ND MAMES Provider called NDMA on a couple of accounts where the Provider had sent the claim EMC with the PA #'s three or four times and NDMA had denied every time as denial code 62. What the Provider was told was that sometimes the NDMA system does not recognize the PA # when The Provider submits electronically and the NDMA representative told the Provider to resubmit hard copy with the PA #. The NDMA representative said that on both accounts that the Provider gave NDMA, the NDMA representative could "see" that the Provider submitted the PA #, but the NDMA system did not see it. It's kind of ridiculous that a Provider should have to keep resubmitting these when the Provider has done it correctly the first time.

RESPONSE: An example was submitted by a DME provider and reviewed by Julie J. (Claims Supervisor). The claim was submitted inappropriately by the provider. The claim did not match the prior auth so was denied appropriately with a 62 denial reason. The NDMA representative should have explained in detail why the claim was denied rather than direct the provider to resubmit.

DISCUSSION: No further discussion.

APNEA MONITORS

Generally, an apnea monitor is only covered if the infant has respiratory distress or is having breathing problems.

However, some physicians are prescribing infant apnea monitors as medically necessary when an infant is on oxygen and the apnea monitor is used to alarm parents.

This would be in the event they have trouble breathing because the cannula or other means of administering oxygen may have been accidentally removed and infant is not capable of putting it back on. Would medically-necessary coverage be considered in this situation?

RESPONSE: Why would a physician order an apnea monitor vs. an oximeter in this case? What has been the physicians practice in the past and what other options are there? \$57.20/month (oximeter) vs. \$177.39/month (apnea monitor) rental fee.

DISCUSSION: NDMA will follow our coverage criteria as define in the 2006 DME manual.

REIMBURSEMENT FOR LABOR

In a recent prior authorization sent to NDMA a ND MAMES Provider submitted a labor fee of \$720.00 and NDMA approved \$200.00.

It appears that no matter what the labor rate the Providers indicates on the prior authorization, NDMA unilaterally changes it. What is determining factor that is used when labor is paid?

RESPONSE: We will no longer restrict providers to a \$200 limit on labor; however, documentation must be provided and support the number of units billed for the actual time spent on the repair. Prior authorization is still required for labor.

It is not appropriate to bill a base labor charge of 60 minutes and then add the actual time spent in additional 15 minutes increments, nor is it appropriate to bill separately for labor involved in fabricating custom seating systems/custom items as this is already taken into consideration when calculating the reimbursement of the seating components/custom items.

DISCUSSION: No further discussion other than one provider recently had a PA with labor and they will resubmit for reconsideration of the labor.

PREVIOUS QUESTION FOLLOW-UP

ND MAMES Providers understand the need for utilization review but it creates so much paper work. Providers can request that Medicare not automatically cross over claims to NDMA. Pamela Pfaff, Great Plains Rehab, made a comment that Medicare will deny claims with a CO when then have reached the capped rental period and that this may be a way for NDMA to determine when the rental period has been capped rather than requiring PA. This would help the providers significantly with cross over claims for rental items. NDMA will need to research this suggestion and will report back to the Providers at the next schedules meeting.

RESPONSE: The current system is not capable of this function but will consider this request when designing the new MMIS system.

DISCUSSION: No further discussion.

PREVIOUS QUESTION/ANSWER

3. A June 2007 question regarding billing in the SNF was turned over to the legal department and is in a working status. Has the legal department rendered an opinion?

BILLING IN SNF

HME providers are required by Medicare regulation to bill the beneficiary the remaining 20% of the allowed amount on Medicare covered items. When we provide a covered item to a beneficiary in a Skilled Nursing Facility (SNF) ND Medical Assistance will not allow separate reimbursement for these items because they are included in the "per diem" to the facility. The majority of the customers HME providers service in facilities have ND Medical Assistance as their secondary payer. What are our HME provider options in these situations? HME providers are not allowed to bill the facility. ND Medical Assistance has previously told HME providers that it is their decision/payment is considered final because you are the last payer of record. HME providers are mandated by Medicare regulation not to waive these co-pays to help reduce fraud in the Medicare program, the Office of Inspector General is actively investigating health care providers, practitioners and suppliers of health care items and services who (1) are paid on the basis of charges and (2) routinely waive (do not bill) Medicare deductible and co-payment charges to beneficiaries for items and services covered by the Medicare program. A provider, practitioner or supplier who routinely waives Medicare co-payments or deductibles is misstating its actual charge. For example, if a supplier claims that its charge for a piece of equipment is \$100, but routinely waives the co-payment, the actual charge is \$80. Medicare should be paying 80 percent of \$80 (or \$64), rather than 80 percent of \$100 (or \$80). As a result of the supplier's misrepresentation, the Medicare

program is paying \$16 more than it should for this item. A provider, practitioner or supplier who routinely waives Medicare co-payments or deductibles could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). What Penalties Can Someone Be Subject to for Routinely Waiving Medicare Co-payments or Deductibles? Whoever submits a false claim to the Medicare program (for example, a claim misrepresents an actual charge) may be subject to criminal, civil or administrative liability for making false statements and/or submitting false claims to the Government. 18 U.S.C. 287 and 1001; 31 U.S.C. 3729; 42 CFR 1320a-7a). Penalties can include imprisonment, criminal fines, civil damages and forfeitures, civil monetary penalties and exclusion from Medicare and the State health care programs. In addition, anyone who routinely waives co-payments or deductibles can be criminally prosecuted under 42 U.S.C. 1320a-7b(b), and excluded from participating in Medicare and the State health care programs under the anti-kickback statute. 42 U.S.C. 1320a-7(b)(7). Finally, anyone who furnishes items or services to patient substantially in excess of the needs of such patients can be excluded from Medicare and the State health care programs. 42 U.S.C. 1320a-7(b)(6)(B).

RESPONSE:

DISCUSSION: NDMA continues to work on this issue. Providers are to continue with their current billing practice until further notice.

SPECIAL CONSIDERATION TO CERTAIN MEDICAL PRODUCTS

ND MAMES Providers have been told that non-covered items would be looked at on an individual basis. A Provider sent in a prior authorization for a shower gurney. This individual had been living for 10 years at a nursing home. His mother moved him home in order to care for him. NDMA purchased a new wheelchair, seating system and a Hoyer Lift for the NDMA beneficiary. In order for his mother to bathe him a request was made for the shower gurney. This service was denied by NDMA as non-covered Adaptive Equip for Daily Living.

The parents went on to request payment for this service from a "special fund" at NDMA and it was paid for.

The ND MAMES Provider's question is this; If NDMA purchased equipment so the client could live at home and save the state thousands of dollars a month why would they not pay for bathing equipment. Providers are told special consideration is made when circumstances warrant it. Would this not have applied here?

RESPONSE: Items determined not reimbursable by the State Plan (general) Medicaid can be considered for payment thru waived services for those recipients that qualify for waived services.

DISCUSSION: Maggie Anderson discussed criteria that needs to be met for waived services and essentially Medicaid pays for this type equipment regardless if it is thru the waiver or traditional Medicaid plan.

POWER CHAIRS COST + 20%

A ND MAMES Provider is putting together a group three standard power chair with seat and back. The retail price is \$6,500; the Provider's cost is \$3367 with their secondary discount. The patient (who is a child) is NDMA only.

NDMA is allowing \$4,303.52 while Medicare will pay \$5,288.44 and BC/BS will pay \$5,812.80 on the same wheelchair.

The Provider can actually make an additional \$250 by not paying his vendor's invoice within 15 days...and not take the secondary (quick pay invoice) discount.

Therefore, NDMA current payment method (cost plus 20%) does not incentive a Provider to lower their cost. In fact, the Provider benefits from not lowering their cost.

RESPONSE: Cost +20% does not apply here as there is a set fee on the fee schedule. Items billed under a miscellaneous code would fall under the cost +20% payment systems. In those situations all discounts must be extended to NDMA.

DISCUSSION: Providers were encouraged to develop a work group to gather data related to DME issues and reimbursement which they could present to Maggie Anderson by June 13, 2008

Agenda items:

- Place of residence must be current and accurate on the PA
DISCUSSION: Providers need to work with new and current staff to ensure the information submitted on the PA is current and accurate to insure proper adjudication.
- Can bill overlapping months but not more than one month per claim. Example: March 15 to April 14
DISCUSSION: None
- Incomplete priors/CMN's causing delays in adjudication and they will be sent back. Poor quality and difficult to read. Missing prior auth numbers on the claim. Use modifiers on the PA and claims.
DISCUSSION: None.
- Exceeding limits/split billing
DISCUSSION: None.
- D41 denial/provider responsible – Do not bill recipient
DISCUSSION: Allowed 90 days retro to submit a PA. Would recommend securing a PA before dispensing whenever possible.
- Wait 3 weeks before calling provider relations and inquiring on PA receipt
DISCUSSION: None.
- Bill monthly with FROM and TO dates on the claim Example: Diapers- dispensed qty of 180 on May 15. Claim should have dates of May 15 to June 14 with a qty of 180. Some providers are billing May 15 qty of 120 and then again on May 25 qty of 100.
DISCUSSION: None.
- July –Inflationary increase of 5%.
DISCUSSION: Effective for date of service July 1, 2008/

ADDITIONAL DISCUSSION:

Due to the implementation of the new MMIS system all providers will need to re-enroll January 2009. Training will occur at that time. Notification will be sent to all providers regarding this process.

Some priors are approved for 12+ months if the physician has identified a lifetime need. Example: Oxygen equipment - may be approved for 36 months if the Dr. has identified clearly on the Rx that there is a lifetime need. The equipment would be considered patient owned after the 36 months of approved rental.



Top 10 Errors By
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